UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ENBREL (enteracept)for JUVENILE IDIOPATHIC ARTHRITIS

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO 855-828-4992

CRITERIA:

- Age requirement: 2 years old and older
- Diagnosis of Juvenile Idiopathic Arthritis
- Documentation of failed treatment on at least one DMARD.
- Negative TB skin test within the previous 12 months or history of treatment for latent TB infection.
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Rheumatology consultation within the last 60 days.
- May not be given with other biologic agents such as Interferon, experimental medications or combinations.

NOTES:

Available as a Non-Traditional Medicaid Benefit.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

An updated letter of medical necessity or progress notes showing improvement or maintenance with medication